BOSTON UNIVERSITY
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THE FUNCTION OF THE SOCIAL SERVICE DEPARTMENT IN THE BLANK STATE HOSPITAL, IN THE RELEASE AND SUPERVISION OF PATIENTS DURING THE STATISTICAL YEAR 1940-1941

A Thesis

Submitted by

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Part I

INTRODUCTION

The study of the Function of the Social Service Department in the Blank State Hospital in the Release and Supervision of Patients During the Statistical Year 1940-1941 was undertaken to provide the hospital with basic social information concerning the supervision of patients . This study was designed to gather information related to supervision, to throw some light on the problem by finding out what had been done and what could be done by social service workers, and to answer the following questions. Under what circumstances were patients released from the hospital? How long had they been in the hospital before release? What were their ages? What were their medical diagnoses? What was their education? Their intelligence? In what occupations were they employed after release? To whom were the patients released? Did the patients have a court record before admission? After release? What was their conduct record for asocial and amoral trends? What was their alcoholic history? What were the other social factors in these cases? How could the social problems be classified? What emotional problems were present? How could the results of social service supervision be evaluated? How did the patients' social adjustment compare with that before admission?

It was impossible to conduct a study of this nature by examination of all the case records of all the patients on visit from the hospital, because of limitation of time, and also the incompleteness of the records. Consequently cases were selected with the following criteria: records of patients who had some social service investigation before release, who had been under supervision for at least four months, and who had been contacted at least three times following release on visit. An attempt was made to select those cases which would permit generalizations pertaining to the patients most closely supervised by the social service department. An important part of the work of the social service department of the state hospital, from the social standpoint, is the supervision of patients on visit . This supervision has a wide range from the simplest type of visit where practically no help is needed (with families who are understanding and cooperative) to treatment under the supervision of the psychiatrist with close cooperation of psychiatrist and social worker in agreeing upon satis - factory recommendations, and on treatment.

On October 31, 1941, the closing date of the statistical year, there were 497 patients on trial visit from the hospital. Of these, 39 cases had been under close supervision during the year. The cases were considered to be under close supervision provided they had some investigation

prior to release, and had at least three contacts with social service, sometimes many more, during a four months' period or longer. Twenty of these cases, or slightly more than fifty percent, were selected at random for intensive study. The sample was tested for race, sex, age, and diagnosis by comparison with the total number of patients under close supervision during the statistical year. (See Tables I and II). The sample seems to be representative of all the patients supervised in respect to these characteristics. It was planned to conduct the investigation so that conclusions might be drawn which applied to the entire field, although only fifty percent of the cases were actually examined in detail.

The representativeness of the sample may be shown by the following tables:

TABLE I RACE, SEX, AND AGE OF PATIENTS UNDER SOCIAL SERVICE SUPERVISION AT THE BLANK STATE HOSPITAL 1940-1941

Factors		20 Selected Cases	39 Cases Under Close Supervision
Race	White	20	38
	Other	0	1
Sex	Male	7	12
	Female	13	27
Age	Range of ages	6- 75	6- 75
	Median age	36	40

TABLE II DIAGNOSES OF PATIENTS UNDER SOCIAL SERVICE SUPERVISION AT THE BLANK STATE HOSPITAL 1940-1941

Diagnosis	20 Selected Cases	39 Cases Under Close Supervision[a]
Alcoholic Psychosis	4	10
Dementia Praecox	6	11
Manic Depressive Psychosis	3	6
Other	7	12
Total	20	39

a Including the 20 Selected Cases.

The case study method was used in this study. The data were collected case by case, by examination of recorded material, namely the case records of the Blank State Hospital. The statistics were compiled from this examination of material, and the limitations characteristic of case studies were here apparent-- namely, the accuracy of records, the completeness of records as to material, and the problem of subjectivity.

The writer had had previous contact with all the cases, and some information about all the cases under supervision. Therefore there was as much uniformity in

gathering and recording the material as could be obtained, taking into account that the original material was written by various workers. The interpretation of the records , when not clear, was made by consultation with the worker who had originally written the case material.

The material contained in the case records was sup - plemented by data collected from the Massachusetts Board of Probation as to court records, and from the Social Service Index in Boston as to social agencies to whom the patient or his family were known. This material was recorded as of December 23, 1941. These data were collected for the purpose of making the study more complete, and the evaluation more objective, so that from these reports certain conclusions as to the patient's adjustment to the community might be drawn.

The schedule[1] used in collecting the material contained items including race, sex, age, schooling, time in the United States, economic status on admission and when last visited, family group, court record, social analysis, evaluation of social service supervision. The schedules were filled out and edited, and the material analysed and classified by the writer.

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1 For a copy of the schedule and definitions of terms used in the study, see Appendix A.

Part II

PSYCHIATRIC SOCIAL WORK

General Theory

Psychiatric social work deals with the individual and social adjustment of persons suffering from mental disease and defect. It requires an understanding of human personality and its reactions to environment. In the state hospital its function is that of a specialized service working directly with a psychiatrist for the adjustment of the patient. The social worker in a state hospital needs a knowledge of the nature of the mental processes that may cause conduct disorder-- repressions, obsessions, interests, desires, attitudes of thinking, feeling, and wishing conditioned by early experience; also intelligence, emotion, and instinct. She looks at the patient's desires and attitudes as a clue to his motives and wishes, or his motivation. She watches his interests as a clue to shaping plans for treatment. He may be interested in or wish for recognition or social status; response or affection; security of home or job; security in relationships; new experience; to serve; for power; to belong; for workmanship, or the satisfaction of a good job done. The psychiatric approach is the dynamic approach-- looking underneath for the motives. The aim of psychiatric

social work is the understanding and influencing of human behavior, for the best possible personality adjustment. The psychiatric social worker places greater emphasis than other social workers on the study of the individual in relation to his whole social situation.

The major objective of social treatment is a better social adjustment for the patient and the highest degree of self-direction, independence and self-maintenance of which the individual is capable in his environment. The focus of the psychiatric problem is on the need of the patient, on his behavior in his environment, and why he has to behave as he does. The emphasis is on his need for redirected attitudes, for better relationship with other members of the family, and with others. Skillful supervision on the part of the psychiatric social worker will help the patient to adjust more adequately to his work, his family and others.

To understand the patient information is necessary regarding his environment, past and present, and his reactions to it, for these stresses have usually played an important part in the patient's background. The patient's relationships within the family situation, both current and earlier, as well as his social relationships are especially important. The social history will not cure the patient's illness but it may contribute dynamic material indicating what treatment

is necessary to relieve the condition.

In order to understand the patient and treat him effectively he must be studied as an individual reacting to his own specific environment. He is seen, understood , and helped in relation to his environment. There is a psychological situation. In order that the psychiatrist and the psychiatric social worker in the Blank State Hospital may have a better understanding of the personality and environment of the patients admitted, the first duty of the psychiatric social worker is to secure the case history from relatives and others who know the patient best in the work situation, in the home, and in other social relationships. The social history gives those studying the patient the positive factors of the individual, and the strengths as much as the weaknesses. It points out the limitations of the client and his environment.

The chief activity of the psychiatric social worker is that of case work. The social treatment of the pa - tient and his environmental situation may be of as much importance in promoting his recovery as any other treat - ment he receives from the hospital. Social service should be regarded as an integral part of the whole approach to the solution of the patient's difficulties. In no illness can an individual's problems be regarded as isolated units, and this is especially true of mental illness.

The techniques used in psychiatric social work include the listening technique; manipulation of the environment, or redirecting attitudes of others towards the patient; supportive or sustaining treatment, such as appealing to a patient's pride; and deeper therapy, which in the Blank State Hospital is practised only by the psychiatrist. Some of the results of treatment are: better adjustment to work, family, parents, and others, under the supervision of the social worker; a greater feeling of security; a lessening of the nervous strain in the home; an elimination of some of the patient's mental conflicts and feelings of guilt under psychiatric guidance.

In order to reach the goal of psychiatric treatment,[1] which is the fullest achievement of self-acceptance, self-direction, self-expression and self-realization of which the patient is capable in his environment, a social diagnosis is made. This is a diagnosis which is used as the basis of treatment. The social diagnosis contains certain material, including first, the personality of the individual who possesses the problem, and second, the social situation in which the individual manifests the deviated behavior which indicates the difficulty within the personality.

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1 Much of the following material is taken from lectures on "Psychiatric Social Treatment" by Miss Ina L. Morgan at Boston University School of Social Work,1938-1939.

The psychiatric-social diagnosis is stated in terms of a behaving personality reacting in specific ways to specific situations. The purpose of the diagnosis is to secure as accurately as possible an understanding of the personality as a whole, also the personal evaluation which he makes of his total life experiences and his characteristic attitudes and reactions to them.

The problems of individuals needing psychiatric social understanding and assistance are usually in one or more of the following areas:

1. Social relationships in which each individual has a definite responsibility for creating and maintaining helpful relationships which will provide him a reasonable amount of pleasure and satisfaction.
2. The area of economic or educational responsibility in which an adequate status may be achieved within or to the limits of the individual's potentialities and provide a satisfaction and strength derived from creative activities.
3. The area of mental life in which each individual needs to develop and maintain an attitude towards life or a philosophy which will yield him not only a reasonable degree of satisfaction and joy in living, but enable him to face and accept life as it

is without exaggerated fear and anxiety. In fact, in this area each individual needs to possess a faith, confidence, and courage to endure the struggles and difficulties of life which are common to us all - and even the disasters of life without warping or distorting one's personality.

The psychiatric-social diagnosis is the basis for social treatment. Psychiatric social treatment is a professional service to an individual who is unable to achieve a satisfying and effective degree of self-acceptance, self-direction, self-expression and self-realization. It covers personality growth, social adjustment, reasonable satisfaction.

In general there are three sets of factors which have a strong interplay in social treatment:

1. The function of the agency.
2. The professional qualifications of the worker.
3. The factors inherent in the client's total situation which determine the treatment possibilities in any given case.

The major concepts involved in psychiatric social treatment include the following:

1. The practise of psychiatric social treatment is on a relationship basis, not leadership or projection of a plan.
2. Treatment is a step by step process, developing

from each contact, with a possible change of emphasis at every contact.

3. Whatever the need of the client, the social worker cannot develop beyond her own knowledge and ability to use that knowledge.
4. The family and the group relationships should be kept in mind. The worker can overtreat an individual so he is out of step with his environment, by focusing on the client to the exclusion of the family.
5. The social worker cannot give the client security, confidence, a different personality emphasis, different attitudes.
6. The art of listening is a most valuable tool.
7. It is often possible that a patient who once becomes articulate in a small degree does not necessarily need to reveal the depths of his trouble.
8. The social worker may appreciate, understand, and respect the patient's anxiety, fear, sorrow, disappointment and similar emotional states, but she should never share them.
9. The success of social treatment may be estimated in terms of the attainment of the client of increased self-understanding and self-acceptance, with a resultant increased capacity for solving his own difficul-

ties.

Upon her understanding of the forces which have made the person what he is depends the social worker's ability to render effective assistance in any case. The problem then becomes a broader one than giving relief to a deserted mother, or changing a maladjusted child to a different home or school, or finding a man who is out of work a new job. These material resources are not neglected, to be sure; but along with their use goes a more subtle kind of service, that of personality adjustment. The skilled social worker, even though she may not be able to bring about ideal conditions, can do much to improve personality adjustments even in the more complex problems.

The development of proficiency in the psychiatric social worker has only one ultimate purpose -- to contribute to the well-being of those persons who become the objects of her professional attention. The task of the psychiatric social worker is performed only when her patient, through her assistance, has been put in a position where he can realize his own purposes in life with the maximum satisfaction to himself and to others whose lives are directly connected with his own. In other words, she makes an intimate search for the causes of maladjustment within the life history and personality of the individual who seeks aid.

The key word of the psychiatric approach is individualization. The aim of psychiatric social treatment is a well-integrated personality, functioning as a whole, making a satisfactory adjustment. The patient is seen as a product of his environment. Insight into individual personality is psychiatry's great gift to social work. The psychiatric social worker studies the patient as a whole -- hereditary, environmental, constitutional, physical, social, and economic aspects. She has an understanding of personality relationships -- attitudes, adjustments, feeling-tones. The psychiatric social worker does not treat a problem or an individual, but treats the patient who is an actual individual struggling in his situation in the environment in which he is. For example, she does not treat all alcoholics alike. She recognizes alcoholism as a symptomatic factor. She attempts to discover why the man or woman drinks, and scrutinizes his failure to adjust from every angle. Does he drink because of a feeling of in-security, incompatibility with his wife, because of loss of a job, or for any other reason? How can the worker help him in his relationships with his family and the community? The major objective of her social treatment is a better social adjustment for the patient and the highest degree of self-direction, independence and self-maintenance of which the individual is capable in his environment.

For successful supervision of patients on visit from the hospital one must thoroughly study the personalities of the patient and his family group - their innate capacities, acquired tendencies, social environment, and their reaction to this with a view of getting at the causes of weakness and sources of strength. In treatment one aims to remove the causes of difficulty and use the sources of strength in individuals and their environment. This involves an attempt to adjust the patients and their environment, and depends largely on certain attitudes between worker and client and others, and the use of resources.

There are certain norms or standards of self-maintenance in education, family solidarity, health, religion, recreation, in work and adequate economic provision (including employment or adequate relief), in community adjustment and social relationships (including adequate housing, adequate community resources, neighborliness). The social worker strives to help her patients reach their goals in these directions as nearly as possible, and to do the best that is in them. To this end she uses all her skills and knowledge, in readjusting the habits of mind of the patients; their attitudes of aggressiveness, anxiety, dependency, false pride, self pity; their anti-social behavior; and in adjusting the environment or social situation, including the family relationships, home, occupa-

tional and industrial difficulties, recreation and play , and their sociable and collective life. This will be illustrated in cases described and analyzed later.

The Social Worker's Role.

In the Blank State Hospital, all the 1200 patients admitted during the year 1940-1941 were known to the so - cial service department, besides many who had been admitted previously. The duties of the social service department and the types of situations referred to it were many and varied. In order to assist the psychiatrists in studying the patients, the social worker obtained the medical or psychiatric history as well as the social history. She obtained as complete a story as possible of the patient's life and habits before he came to the hospital. This included his family history, early development, education, religion, asocial or amoral trends, sexual life, occupation, diseases and injuries, alcoholism and other toxic influences, mental make-up or type of personality, previous attacks of mental disorder, precipitating cause of the present mental ill - ness, and onset and symptoms of the illness. Even the causes of death of his grandparents and his parents, his race, and the kind of people he came from help to give a picture of his inheritance. The story of his early development and relationships with his parents and siblings,

especially for young patients, also assists the doctors in understanding him. It is important to find out what fac - tors contributed to his mental breakdown, and what kind of a person he was in his early life and before his breakdown, and how his personality or mental make-up has changed. The doctors need to know also when a change in personality was noticed, and how the patient's mental illness progressed . It helps to know if he has had any previous attacks, what was the precipitating cause of the present attack, and to obtain a description of the onset and symptoms of the psy- chosis. Just how was he behaving at home? When did he stop working? Does he eat well? Does he sleep well? Has there been any change in his memory? Is he a drinking man? If so, how much does he drink? Is he well-adjusted in his sex-life? Has he any physical illnesses which may have brought on the trouble? Has he heard imaginary voices? How does he react to them? What do they say? Has he seen visions? Has he tried to commit suicide or to harm anyone ? What is his attitude towards his family? Towards his employer? Towards others with whom he comes in con- tact in the community? Knowing the answers to all these questions about the patient's past helps to give a more com- plete picture of him.

The social worker tries to assist the relatives at the time of taking the history, and to make a good contact with

them. Even at the time of the patient's admission she attempts to lay the groundwork for plans for his leaving the hospital as soon as he has improved sufficiently. She does not usually secure the best results by direct questioning, but often by letting the relative tell the story in his own way. She uses the listening technique. This first contact with the family of the patient, to secure the social history, becomes a first step in

> ... the important process of social treatment, which later is to involve explanation to family, further understanding of the family situation, preparation for the return of the patient, and follow-up after his discharge. Viewed in this light, a social history ceases to be data about a patient and becomes a first step in a relationship shared by patient, worker, and family, which, closely related to the psychiatric and medical diagnoses, is the vehicle for effective treatment.[1]

The social service department makes full investiga - tions of court and observation cases. This includes registering with the social service index, contacting agencies who have known the patient or his family, interviewing other relatives who can give further information about the patient's life, and obtaining information from the school , court and police officers, previous doctors and others who have known the patient. The social worker is the only member of the hospital staff who goes out into the community in this manner. While securing the history or making the

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1 Lois Meredith French, Psychiatric Social Work (New York: The Commonwealth Fund, 1940), p.127.

full investigation, she is constantly watching for social situations which she can help the patient or his family to solve.

The hospital is a very abnormal place for the person who is not used to it, and he likes it less when he is sick, a time when he feels he does not want to be a part of a big group. One of the duties of the hospital social worker is to explain the hospital to patients, their families and others. She explains the rules about visiting hours, various treatments, occupational therapy, the function of the social service department.

A social worker's time is mostly taken up in interviewing relatives, obtaining histories, and supervising and investigating patients in the community. The social worker does not have very much to do with the patient while he remains in the hospital, but sometimes she can help to interest his relatives in him, find his bankbooks, make a plan to aid his family at home while he is sick in the hospital, place his children in a foster home until he can take care of them again, and do other things which, by easing his mind of his real worries, will hasten his recovery. The social worker learns about these things she can do to help the patient by an interview with the pa - tient on the ward or by referral from a doctor.

The nature and duration of the contact of worker and

> family during the period of hospitalization depends upon the circumstances of each case. In certain types of mental disease the social conditions may reveal only a slight relationship to the progress of the disorder or may hold little hope of aiding in recovery. In others, family relationships may have played an important part in the patient's breakdown. Many times such conditions are amenable to social service treatment and should have the attention of the hospital social worker during the entire period of the patient's hospitalization. Other family situations may clear up as the result of a brief period of treatment. The important factor is to see that the treatment which the situation demands is given. Obviously, the decision as to the treatment which the situation demands grows out of the diagnosis at the time a patient enters, a diagnosis resulting from the medical and psychiatric examinations and the study of the social situation.[2]

It is the social worker's duty to supervise patients who are on visit from the hospital, but she gives close supervision to only a selected few. These are referred by the staff, by outside agencies, or selected by the social service department as particularly in need of social treatment. It is usually when the social problem is especially acute that the social worker supervises the patient in the community. It is due to the pressure of other duties that the social workers in the Blank State Hospital do not supervise more patients in the community.

> With the return of the patient to his community, the social worker's task is to aid him in meeting again the relationships of home, family, friends, and employers. Contacts with those in touch with the patient, following up the pre-parole preparation, are

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2 Ibid., p. 129.

made with the aim of insuring more understanding treatment. Contact with the patient himself gives him an opportunity to discusssdifficulties in his situation and his attitudes toward them.[3]

In this latter relationship, direct contact with the patient, the role of the social worker varies. In a hospital program which includes parole clinics, the patient as a rule returns at certain intervals to discuss his situation with the psychiatrist. In such cases the social worker may have little direct contact with the patient himself. In other situations, the patient is in touch with both psychiatrist and worker. Again, because of her knowledge of family and community relationships, the social worker often carries responsibility for judgment as to whether the patient's adjustment is satisfactory or whether another break - down is imminent, necessitating his return to the hospital.[4]

From the social standpoint, the supervision of pa - tients on visit is the most important part of the work of the social service department of the state hospital. This supervision has a wide range, from the simplest type of visit where practically no help is needed to therapy under the supervision of the psychiatrist with close cooperation of psychiatrist and social worker in agreeing upon satisfactory recommendations, and upon treatment.

When the patient is ready to leave the hospital, the psychiatrists often refer him to the social service de - partment for a home investigation before his release.

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3 Ibid., p. 129
4 Ibid., p. 129

Some patients recover from their mental illness and can be discharged to take up life in the community. Others improve sufficiently so that they can get along in the community if there is some one who understands them and can give them the care they need. Some have relatives who are able and willing to take them, and there is not much doubt in the doctor's mind but that the patient will get along with them. These patients are often released on trial visit, and the social worker has little contact with them at the time of release. They report to the psychiatrist in the out-patient department about once a month for a year. "On visit" or "on trial visit" means that the committed patient is released from the hospital for a year's trial in the community, at the end of which period he will be discharged and no longer under the supervision of the hospital. He may be released as improved or unimproved, and may be released against advice or with the approval of the hospital staff. If he is recovered upon release, he is discharged, not placed on visit.

The majority of patients are released to relatives, but some do not have suitable homes, or families who can care for them. If the social worker has taken the history and made a full investigation, and also kept in touch with the relatives while the patient has been in the hospital, she may have a good idea about the home. If there

is any doubt about the home, the worker makes a home investigation. She tries to find a relative who is willing and able to take the patient. She explains the situation, the patient's present condition, and the doctor's recommendations. She also finds out about the suitability of the relative's home -- who lives there, where the patient would sleep, whether the income is sufficient for the patient to be assured of suitable food and care. She explains the rules of the hospital, for example, that while the patient is on trial visit he can be returned to the hospital at any time his condition warrants this move. The social worker makes her report to the doctor, and if the home seems suitable, and the patient has improved sufficiently so that it is thought he will adjust outside the hospital, he goes out on trial visit. If there is no relative who can or will take the patient, and he is ready to leave the hospital, some place must be found for him to go, and this also is the social worker's problem when the case is referred by the doctor. Sometimes patients are tried in family care or boarding homes. These patients are still under the supervision of the hospital, which pays for their care, but they live in private boarding homes in the community and are given an opportunity to get along outside the hospital and often, as they improve, these patients find employment or at least a place to live useful lives

in the community without returning to the hospital.

In other cases the social worker finds boarding or nursing homes for the patients, and interests another agency in paying for them. She assists the patients to find a place to live, employment, or whatever they need to make a good adjustment in the community.

During the year's trial visit, the patient is under the supervision of the hospital, and is expected to report to the psychiatrist in the out-patient department once a month or oftener, and it is the social worker's responsibility to see that he reports. The social worker supervises many of the patients who are on visit, but gives close supervision to only a selected few. The latter are referred by the staff, by outside agencies, or selected by the social service as particularly in need of social treatment. It is usually when the social problem is especially acute that the social worker supervises the patient in the community. It is due to the pressure of other duties that the social workers in the Blank State Hospital do not supervise more patients in the community.

PART III

CERTAIN CHARACTERISTICS OF THE PATIENTS UNDER CLOSE SUPERVISION BY THE SOCIAL SERVICE DEPARTMENT.

It is the purpose of this study to examine closely the patients under close supervision by the social service department. To do this an analysis was made of certain characteristics of the 20 patients who were most carefully studied.

All 20 patients were of the white race. Seventeen were born in the United States, one in Italy, one in Canada, and one in Ireland. Seventeen were United States citizens by birth, and two by naturalization. One was an alien. Thirteen were Roman Catholics by religion, three were Protestants, three Hebrew, and one Russian Orthodox. At the time of release on visit, eight were single, three married, four widowed, four separated, and one divorced. Of the group studied, thirteen were female and seven male.

Of the group of 20 patients, two stayed in the hospital prior to release on visit less than one month, three less than three months, three less than four months, one less than seven months. Of those who remained in the hospital more than 12 months, six remained less than two years, two less than three years, one less than five, one less than six years, and one over 26 years. This may be made clearer by the following table:

TABLE III LENGTH OF HOSPITAL STAY OF 20 PATIENTS UNDER SOCIAL SERVICE SUPERVISION AT THE BLANK STATE HOSPITAL 1940-1941

Years	No. of Patients
Under 1 year	9
1-1.9	6
2-2.9	2
3-3.9	0
4-4.9	1
5-5.9	1
6-6.9	0

Over 26	1
Total	20

There was a very wide variation in the ages of the patients, on their last release on trial visit. The ages were scattered between the six-year-old girl, and the elderly woman of 75. The median age was 36. There were three patients under 19, nine between 20 and 39, five between 40 and 59, and three between 60 and 79.

Five of the 20 patients had had only a common school education or less, eight attended only grammar school and

two of these completed grammar school. Of the seven who attended high school, two completed two years, three completed three years, one left a month previous to gradua - tion, and one was graduated from the four-year high school course. None of these patients attended college, but one who did not graduate from high school attended art school also, and the one who was graduated from high school had three additional years in a special school for physical hygiene and dietetics.

Not all the patients were given intelligence tests, but their intelligence was recorded as follows in the hospital records:

TABLE IV INTELLIGENCE OF 20 PATIENTS UNDER SOCIAL SERVICE SUPERVISION AT THE BLANK STATE HOSPITAL 1940-1941

Intelligence	No. of Patients
Low	6
Low average	1
Average	9
Above average	2
High average	1
Superior	1
Total	20

The highest intelligence quotient recorded was 137, and the lowest was 65.

The court records may be summarized as follows: two patients had one arrest prior to admission, one had three, one had six, and one nine. Minor traffic violations were not counted in this tabulation. One of these patients had served four jail sentences, and two patients served one jail sentence each. There were no arrests of patients after release from the hospital, as far as could be ascertained by the Massachusetts Board of Probation records.

This lack of arrests following release may be partially explained by the fact that the record for arrests before admission was taken from the patient's whole life record , and his record for the period following his release covered only a few months. These patients on visit were closely supervised, and did not have as good an opportunity, and perhaps not the same inclination to get into trouble as formerly. The mere fact of having to report to the hospital once a month, and of being visited by the social worker frequently would, in some cases, act as a deterrent. The knowledge that the patient was on trial visit but still under the hospital supervision, and could be returned to the hospital if the need arose because of his behavior, probably kept some of the patients from committing crimes.

The patient with the largest number of arrests-nine-

was a 75-year-old woman, who would obviously not be so likely to commit crimes for which she might be arrested at that age as previously. However, her last arrest was two years before admission, when she was 73. The same charge was made as for several previous arrests -"keeping a house of ill fame", a charge brought against her at various times during a 16-year-period. The patient with the next largest number of arrests was also a woman, and there were a number of different charges against her, including drunkenness, larceny, and lewd and lascivious conduct. As she drinks whenever life becomes difficult, and as she has an unstable personality, it is probable that she will be arrested again. Social service supervision will, however, help her to adjust to life outside the hospital, and possibly reduce her drinking to a minimum.

It is difficult to classify the occupations of the 20 patients studied, but a table of their occupations before admission and when last visited is helpful.(TableV).

In five cases, the occupation and economic status was about the same after release from the hospital, as before admission. In several other cases, the status had improved. The girl who had always been a domestic but who secured a position as a waitress seemed to derive much more satisfaction from this type of work, because of

TABLE V OCCUPATION OF 20 PATIENTS UNDER SOCIAL SERVICE SUPERVISION AT THE BLANK STATE HOSPITAL 1940-1941

Occupation	Male		Female	
	Prior to Admission	On Visit	Prior to Admission	On Visit
Agriculture	0	1	0	0
Public Service	3	2	0	0
Professional Service	0	0	2	2
Domestic and Personal Service	2	2	1	5
Clerical Occupations	1	0	2	2
In school	1	0	2	2
Unemployed	0	2	6	2
Total	7	7	13	13

the more definite working hours, better pay, and greater opportunity to meet others of her own age. The woman who had been dependent on her husband for support even though separated from him, was pleased and much better adjusted when she obtained work as a sewer in a factory and became independent financially. The young woman who had been chorus girl, salesgirl and clerk, as well as housewife, would have liked to work after her release from the hospital, but decided to give up working for a while in order to care for

her two young children, and is now receiving a fairly adequate allowance for them through a social agency. She is content to remain at home for the time-being, and to pursue a hobby for which she has considerable talent and with which she hopes to make a living later. The man who was formerly a laundry-worker, but who had been a patient in the hospital for 26 years, and much of that time had done cafeteria work, was found employment outside the hospital which was quite similar. The young woman who had been a dietetics and physical hygiene teacher was unable to return to the same work because of partial deafness . She was found a position where she had charge of purchasing and preparing the food for a staff of seven, and where she could use her training and experience to good advantage.

Most of these patients do not have relatives on whom they may depend for support, and it is therefore imperative that they be cared for in some other way. To find a position for a patient who is recovering from a mental illness or for one who may never be recovered although he is improved, is not easy. It takes considerable time, effort, and perseverence, as well as skill. The worker must be very patient with the individual who has lost confidence in his own ability, and in some instances has lost the desire to leave the hospital, and dreads living out-

side this protected environment. Considerable case-work must be done with this individual before he is even ready to be helped to look for work. He is often fearful of approaching a prospective employer, and sometimes bursts into tears during the interview. The employment agency or employer must be convinced of the worth of the patient as an employee, and often needs assurance that he is not dangerous. There are other problems connected with the employment of patients, including living conditions in certain positions, contacts with fellow-emplyees, and keeping the patient on the job. It is, however, worthwhile when a patient is helped to secure and hold a position which helps him to make a more satisfactory adjustment to his environment outside the hospital.

The medical diagnoses showed a wide scatter. (Table VI). Nine of the 20 patients studied had a functional psychosis. Three of these were diagnosed manic depressive psychosis, and 6 dementia praecox. Thus 30 percent of the cases were diagnosed dementia praecox. According to Dunham, schizo - phrenia (or dementia praecox) constitutes between 25 and 40 percent of the first admissions to hospitals for mental disorders.[1] Four of the cases were diagnosed Alcoholic Psychosis.

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1 H. Warren Dunham, "The Ecology of the Functional Psychoses in Chicago", American Sociological Review, 2:469, August, 1937.

TABLE VI MEDICAL DIAGNOSES OF 20 PATIENTS UNDER SOCIAL SERVICE SUPERVISION AT THE BLANK STATE HOSPITAL 1940-1941

Medical Diagnoses		No. of Patients
Alcoholic Psychosis		4
Alcoholic Psychosis	1	
Other Types	1	
Korsakow's Psychosis	1	
Chronic Hallucinosis	1	
Dementia Praecox		6
Simple	1	
Paranoid	3	
Other Types	2	
Manic Depressive Psychosis		3
Depressed Type	0	
Manic Type	2	
Mixed Type	1	
Paranoid Condition		1
Primary Behavior Disorders of Children, Conduct Disorders		1
Psychosis with Cerebral Arteriosclerosis, Paranoid		1
Psychosis with Mental Deficiency, Moron		1
Psychosis with Syphilitic Meningo-Encephalitis, Paranoid		1
Psychoneurosis, mixed psycho-neurosis		1
Undiagnosed Psychosis		1
Total		20

In his studies of the geographical distribution of social data Dunham found that in Chicago

> . . . there are a few communities close to the center of the city which have extremely high rates of schizophrenia, while the bulk of the communities have much lower rates. The highest rates for schizophrenia are in the hobohemia, the rooming-house, and the foreign-born communities close to the center of the city . . . the disorganized areas of the city.[2]

The same writer found an absence of a typical pattern in manic-depressive psychoses. There were high rates at the center and also on the periphery, whereas in the schizophrenic distributions, there was a complete absence of high rates in the outlying communities. He found a tentency for the manic depressive cases to come from those urban areas with a fairly high cultural level, but the opposite was true with the schizophrenic cases. There was also a tendency of the manic depressive cases to come from a higher social and economic level, as compared with the schizophrenic cases.

Some of the implications of Dunham's study are that

> . . . environment is a very potent factor in the etiology of the schizophrenic disorder, but plays no part in the manic depressive disorder. It would then follow that, if environmental factors are not significant in manic depressive psychosis, there is a certain justification for asserting the priority of hereditary and constitutional factors. . . . Both may be connected with different types of social processes.

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2 Ibid., p. 469

> . . . An explanation of the high rates of schizophrenia in the extremely disorganized areas of the city has been made by stating that persons with schizophrenic tendencies or pre-dispositions drift down into these areas.[3]

It will be interesting to note the part environment plays in the selected cases, for the various diagnoses.

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3 Ibid., p. 479

Part IV

SOCIAL FACTORS AND EVALUATION OF SOCIAL SERVICE SUPERVISION

The social worker is concerned primarily with social treatment.

> Social treatment of the patient and his environmental situation may be of as much importance in promoting his recovery as any other treatment he receives from the hospital.[1]

The social worker directs

> ... attention chiefly to family personalities and problems, and to ways of meeting the patient's needs in the community; the psychiatrist treating the patient and endeavoring to help him integrate his shattered personality.[2]

The following selected case studies show the wide variety of social and personality factors which are significant in treatment, and illustrate the great range in the workers' activities in supervision of patients. Each patient studied had more than one sort of difficulty and most of them had several major ones. All suffered from mental disease, and all exhibited personality or emotional prob - lems more or less marked. For the purpose of discussion, each case has been placed under one of the following groups

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1 Hester B. Crutcher, A Guide for Developing Psychiatric Social Work in State Hospitals (Utica, New York: State Hospitals Press, 1933), p.9.

2 Ibid., p.16

of problems: environmental, physical, sexual, relationship, or personality.

There were five cases with marked maladjustments arising from environmental sources, such as unsuitable surroundings, family friction, marital friction, financial and employment difficulties. (Cases A,B,C,D,E).

Case A represents a 49-year-old widow admitted to the hospital in 1928. The patient was released on visit in 1929, but as she did not make a good adjustment and was most disturbing to her four children, she was returned to the hospital. The outstanding social problems at that time were: loss of her husband while pregnant, trouble over property, maladjustment in the neighborhood, and estrangement from her friends. The medical diagnosis was: Paranoid Condition. This patient had kept in touch with current events and altogether made a better appearance than the average patient, although her intelligence quotient was only 73. In the hospital she was cooperative and maintained a good personal appearance.

For several years during the patient's residence in the hospital, the social worker planned with the lawyer , the guardian, the paternal relatives, looking after the property and the four children, the oldest of whom was 15 in 1929. The worker helped interest the children in recreational agencies such as the boys' glee club and a settle-

ment house. She found the oldest boy a job as errand boy in the clothing business, to earn spending money while still at school.

Thirteen years after the patient's admission to the hospital the oldest son and daughter, young adults, called to see the worker. They stated that their mother had been a patient in the hospital since they were children and they were most anxious to make a home for her if she were well enough. They requested a little time in order that they might find a suitable living place, buy furniture, and establish a new home. At that time they were residing with a paternal aunt with whom they had lived since their mother's admission to the hospital. Two months later, they stated a house had been located and it would be possible to take the patient from the hospital. She was released to the son and daughter, who continued to work to support her and themselves. Although she is still mentally ill and has "paranoid" ideas, she is able to get along in her protected environment.

An analysis of the primary or causative factors in this case shows inferior mentality and personal equipment, a natural tendency to suspicion and over-sensitivity, and a very limited field of interests. Interest in her husband and children excludes all others. Secondary or contributing factors include the loss of her husband while

pregnant, trouble over property, maladjustment in the neighborhood, and estrangement from friends.

Some of the constructive elements in the present situation are: 1. The patient is strong and in good physical health. 2. She is a good housekeeper and gives the children excellent care. 3. She is passionately fond of her children. 4. She is apparently friendly toward the worker. 5. She has a personal friend, who is cooperative and fairly intelligent about the situation. 6. Her pastor is helping constructively and will continue to cooperate.

Some of the destructive elements in the present situation are: 1. The patient's active "paranoid" condition shuts off contact with the outside world. 2. Memories of some real grievances cause her to mistrust everyone. 3.Oversolicitude and indulgence of the children make them re - pressed and unnatural.

The worker helped with the patient's and family's difficulties by interpreting to the patient her "paranoid" attitudes, and by employing the patient's interest in the children's welfare. She investigated the lawyer's standing with a view to determining whether his interests were selfish or altruistic, and tried to ascertain whether the mother's interests and the family income could be extended in any way by the patient.

In this case, the problems were many -- legal, con-

cerning the property; educational, concerning a readjustment of habits of mind of the patient, and also recreational. There were environmental problems, including financial difficulties, and adjustment to a community and a family from which the patient had been separated for 13 years. Above all, there were personality maladjustments of temperament and anti-social habits. The worker did much to help the patient adjust to her difficulties, over a period of years.

Case B is that of a 17-year-old girl of Canadian birth first admitted to the state hospital in 1939 because she became upset after her school chose her to be the leading character in a religious play. She was very pleased and excited about this honor, but also considerably worried. She questioned her teachers who, instead of helping her, gave her the idea that they thought she was out of her mind. She began to think she was someone else, and to talk disrespectfully to her parents and teachers.

This young high school junior, the oldest of eight siblings, had a home setting of emotionality, and an inadequate home life with insufficient income. There was marital discord, parent-child friction, sibling friction. Both parents had had nervous breakdowns, and the father had a court record for drunkenness. He also had a serious physical illness which prevented his working, and was res-

ponsible for a marked personality change in the patient, and for serious marital discord. The mother had heart disease, was seriously anemic, and was a poor manager. The patient was obliged to shoulder considerable responsibility for looking after all the younger children after school hours, and thus she lacked play facilities with children her own age, and her interests were restricted.

The patient seemed to have some conflicts about sex. She attended school only with girls, and never went anywhere with boys. Her mother never gave her any sex instruction, and forbade her to associate with the opposite sex. Shortly before admission, she went to the only dance of her life. The girls walked home with boys, and she was afraid to tell her mother. When the mother found out about it and scolded her, she became quite upset. It was then that she began questioning her teachers, who were shocked and did not help her emotionally.

It was felt by the doctors that the prognosis in this case was good and that it would be of advantage to the patient to place her in a home chosen by the hospital, where her activities could be guided by the hospital social worker. Consequently she was placed at hospital expense in a seemingly desirable home in a small town about 20 miles from Boston. The home group consisted of Mr. and Mrs.M-, a middle-aged couple, and a 19-year-old girl previously

placed in the home by the hospital. Placement was in the spring of 1940 and for the first month the patient made a fair adjustment. She appreciated the home environment after the routine of the hospital, and took much interest in her personal appearance. When seen weekly by the worker she stated that the foster mother was kind, the food was good, and she had an opportunity to go for pleasant walks and do much reading. At the end of the month there was a 10-pound gain in weight, but some discontentment was becoming manifest. The foster mother stated that the patient was stubborn and refused to obey. It was felt by the psychiatrist that this was partly due to jealousy of attention paid to the other patient. The girl gradually made friends of her own age, but the foster mother showed extremely poor judgment in informing neighbors of the patient's hospitalization. Kindness motivated her to beg clothing for the patient from her friends. The girl was embarrassed by such acts, and it was felt advisable to move her to a home where the foster mother would have better understanding and judgment.

Consequently, in the early fall she was moved to an adjoining town where she entered high school as a third year student, became a member of the orchestra and basketball team, and completed the year with high academic grades.

Throughout the year she was visited regularly by the worker in whom she came to have increasing confidence and the two, sometimes with the foster mother included, discussed the patient's difficulties and attempted to guide her future activities.

The question for solution in this case was to find a suitable home for an adolescent girl who needed sympathy , understanding and intelligent guidance. In the social worker's opinion the patient has received much more intelligent advice regarding social contacts, dates with schoolmates, vocational choice, and other normal adolescent problems than she would have received in her own home. She has gained some understanding of the nature of her illness. She frequently goes home for weekend visits, and the foster mother states that she invariably appears nervous and upset on her return. The chief problem at the present time is to effect a better relationship between the patient and her family. Attempts have been made to get her to look at them objectively. She is completing her senior year of high school, has made great strides both physically and mentally since her release, but is still in need of further treatment. She has been out of the hospital for a year and a half, and it is felt that this would have been impossible without a carefully controlled environment and close supervision and guidance.

This girl, who was admitted to the hospital from a home which was inadequate from an economic and social standpoint, and in which she was not making a satisfactory adjustment, is now in a carefully controlled environment, under the close supervision and guidance of the social worker, and getting along well. The difficulty of an understanding relationship with her family is still not fully met, but progress is being made along this line.

Case C represents a 28-year-old married woman admitted to the hospital because she had been drinking heavily, suffering many falls and convulsions. This young woman of superior intelligence showed emotional conflicts centering around her relationship with her husband and his family , which seriously handicapped her social and economic adjustment, and her acceptance of her life situation.

She had a rather inadequate home life both before and after marriage. Her childhood was happy and relatively normal although her mother was nervous, and her father, an optometrist, drank to excess. The patient quit high school within a month of graduation, because "she got sick of it". She also took a business course which she did not complete, and attended art school. Her occupational history is likewise somewhat vague and confusing. She was on the stage as a chorus girl, traveling about the country until she became homesick and decided to return home. She worked in

a dress shop as a salesgirl, and as a clerk in several stores. She has not been employed since marriage.

She has been married seven years and has two children, aged two and five. During the period of her marriage, there has been a decided change in the family's economic status. When they were first married her husband had his own art school and was an artist of some fame and promi - nence. More recently, they have been receiving relief and have been living at his mother's home. The patient did not start to drink to excess until her husband had a nervous breakdown as a result of failing eyesight and consequent loss of work, and was admitted to a state hospital.

In March 1940 the patient had recovered from most of her mental symptoms, and was released on trial visit in the care of the social service, as her husband was still in the hospital. Her diagnosis was: Alcoholic Psychosis, Other Types, condition improved. At the time of her release the patient did not seem to realize fully the importance of giving more attention to the bringing up of her children rather than her own selfish desires of acting and wanting to become an artist. She was quite anxious to have her husband released from the hospital, however, and with the aid of the social worker and a relief agency, she set up a home away from the in-laws with whom she had lived formerly , and took care of her children. When her husband was re -

leased, the family were in their own home for the first time. With the proper diet, both husband and wife improved in health, the husband was able to return to work, and the family seemed quite happy. After the husband's sudden death in February, this woman continued to make a good adjustment outside the hospital. She applied for Aid to Dependent Children, remained in the home taking care of the children of whom she seemed quite fond, and continued with her painting at home. She did not return to her alcoholic habits while under the supervision of the hospital.

The causative factors in this patient's breakdown included emotional conflicts centering around her relationship with her husband and his family, which seriously handicapped her social and economic adjustment; a mentally ill and alcoholic husband; a habit of drinking to excess. Constructive factors on which to build included a cooperative and pleasant, sociable personality; superior intelligence, and a love of her children. The social worker met the patient's needs by adjusting the environment-- helping the patient to establish a home of her own for the first time; aiding her to secure relief for her children; facilitating the release of her husband from the mental hospital so that the family could be re-united. She built up their physical strength by a high vitamin, high caloric

diet, the money for which was supplied by a relief agency, until the husband was well enough to secure and keep a position, which he held until his death. The social worker encouraged the patient to continue with her painting, her chief interest.

Case D represents a 36-year-old married Italian man, with four children from eight to 15 years. The patient was born in Italy and became a naturalized American citizen. There was no history of mental or nervous disease in his family. He had a grammar school education, was of average intelligence, and had good memory and judgment. His wife left the patient one week before his admission to the hospital in January 1941. He was a laborer, and had received some welfare aid. He was a pleasant, sociable man who made friends easily. He was a good provider when he could find work, was much interested in the welfare of his children, and was essentially a home-loving man.

The precipitating cause of his mental illness was given as undue worry over his wife's whereabouts, and over the well-being of his family. The patient looked for his wife for a week but was unable to find her. Then he went to the home of his mother and sister, and seemed so very nervous and frightened that they called a doctor who had him admitted to the hospital. The diagnosis was: Dementia Praecox, Paranoid Type.

The patient was released in the custody of his mother and daughter one month after admission, and went to keeping house for his children. He secured a position in a bakery, but lost it and was forced to apply for dependent aid, which disturbed him. On the other hand, he pointed out to the worker that the children needed their father in the home, and were gaining weight since he had been doing the cooking. Even after his release on visit, he told a long and complicated story of persecution by a gang in connection with his union. He believed that this gang had determined to kill him, and that one of the gang had forced his wife to be unfaithful to him by means of threats. (It is a matter of record that his wife was found guilty of adultery the previous summer).

On her visits to the patient in his home, where he resided with his four children, the worker always found the home clean and the children neat and well-clothed. During the time when the patient had employment, he provided someone to take care of the children between the time they returned home from school and he got home from work. The rest of the time, he did all the housekeeping and caring for the children. When he did not have work, he said that he felt he should remain at home so there would be someone with the children. Though the family received only $11.25 a week from the welfare department, the patient was able to

manage quite well with this amount. At first he made attempts to contact his wife, but more recently he has not done so. The oldest girl felt that the family was better off without the mother, who never adjusted very well with any of them.

This patient was helped to meet his environmental needs, including financial and employment difficulties, by finding him a part-time position, and by connecting him with the relief agency which aided the family when he did not have work. He was assisted in solving his marital difficulties caused by an unfaithful wife by giving him some understanding of his situation and of his children's need for his services. The social worker was able to keep the patient in the community, to help him be a useful member of that community by caring for his children, and to interpret him to other agencies, to the relief agency who helped him financially, and to another agency which did not understand him and because of this attempted to have him returned to the hospital.

Case E indicates a single 19-year-old Jewish boy twice admitted to the state hospital, the second time in 1940. He was the only son in a family of five children. The patient was a gentle appearing boy who told a story of trouble with his mother, who quarreled with him, and did not give him enough food or a good bed. He was admitted to the hospital

because he scratched the attendant whom his mother provided for him.

After the patient had been in the hospital two months, the mother insisted on taking him out against advice, even though he had an intense hatred for her and his sisters, and the doctors felt he might be dangerous if allowed to go home. He was released , and has not returned to the hospital.

The social worker was asked to make a pre-parole investigation. She found that the mother had little understanding of the patient although she seemed to have an overfondness for him. The father, who was intelligent and reliable, stated that the patient never liked his mother and she never cared especially for him or paid much attention to him until after his admission. The father had been separated from the mother since the patient was three. Two sisters were married and not living at home, but the two younger sisters were living with the mother. The sisters, as well as the mother, had a great many feelings of guilt about leaving the patient at the hospital, and they wondered if it were the best for him. The mother caused a great deal of unhappiness to her family by insisting upon their helping her to remove her son from the hospital. She did not seem to care what the rest of the family thought or felt but just wanted to have the patient at home regardless of con-

sequences. The life of this whole family was so colored by this burning question that it was very difficult to proceed with any constructive treatment while it kept reappearing.

It was decided by the medical staff that the patient could be released if all members of the family signed an against advice blnak, and if they promised to supply constant and competent adult supervision. They decided to do this. By this method, and by frequent visits of the worker to see that there was an attendant in the home at all times, the patient was given fairly adequate supervision in his own home, where he lived with his mother and two younger sisters.

Some of the weaknesses in this family were their strong emotionalism, the fanatic devotion of the mother to her son, and the very strong guilt feelings about the patient which were shared by the mother and sisters. The strengths included normal intelligence in the whole family, and the financial means to care for the patient in the home, by careful planning. By close supervision the social service was able to keep the patient out of the hospital, a plan which satisfied the mother. The patient got along fairly well with constant supervision by an attendant, towards the wages of whom all the members of the family contributed. There was less bitter feeling evidenced in the family. The

father was given a chance to accomplish more work than formerly, when the mother's constant demands that he give permission to have the patient out of the hospital had troubled him so that he was unable to work. The social worker helped the sisters, who were afraid of inheriting mental disease and therefore afraid to marry, by discussing this aspect of the situation with them. By keeping this patient out of the hospital under close supervision, the worker was able to help the family make some adjustment to a bad situation.

There were six cases with special physical problems which were factors in the patients' maladjustment, such as deafness (Case F), encephalitis, poliomyelitis, and trauma (Case G), venereal disease (Case H), poor eyesight due to continued drinking (Case I), asthma (Case J), and ulcers and severe brain surgery (Case K).

Case F shows a 35-year-old single woman admitted in August 1940, six close relatives of whom had been mentally ill. She was of average intelligence, and unstable temperament.

This young woman led an active life before her breakdown. She had a good education, including graduation from high school, a three-year course in Physical Hygiene, and a course in Dietetics. She was a bright girl with a great deal of ambition. She taught school for six years, and was

an assistant dietician in a nursery. She was an active, energetic, talkative woman who was well-liked by her many friends, and had a good sense of humor.

For a few months previous to admission, she was forgetful, and was troubled with insomnia and nervousness. Her hearing had been failing for a year, and the instrument which she had just started to use caused her to have headaches and to hear buzzing noises. She became nervous and fidgety and saw imaginary people, including her mother, who died several years before. She was depressed, took an overdose of sleeping-pills, and consequently was admitted to the state hospital. On admission she was extremely over-active and over-talkative, and was treated in hydrotherapy until she calmed down.

After nine months in the hospital, she had improved sufficiently to be tried outside and was released in care of social service. The diagnosis was Undiagnosed Psychosis, condition improved.

The patient's sister worked as a nurse-maid and her only other close relative, a sister-in-law, was employed daily. Both were willing to assist with financial payments in a boarding house until the patient found employment. Such a plan did not seem very constructive since the patient's feeling of inferiority because of her deafness had previously resulted in her accepting positions

beneath her ability, with periods of depression following soon after.

After many afternoons of appointments with personnel directors of various agencies, an interview was arranged with the director of a large neighborhood house. The director was really looking for a cook for the staff, but recognized this girl had more ability. The director proved to have excellent understanding and asked the patient to try the position, promising to give her gradually more responsibility.

After seven months, the patient is a valued member of the staff. She has full charge of the staff house, does all the buying and planning of the meals, and feels that she is more than a domestic. She works with understanding people, and the handicap due to her deafness has been reduced to a minimum.

Possible causative factors in this patient's breakdown included mental illness, a physical handicap, and unemployment. Constructive factors on which to build the patient's adjustment were her intelligence, a likeable personality, and cooperative relatives. Social treatment plans included the patient's readjustment to the community after a mental illness of seven months' duration. This problem was met by the patient and the social worker to-

gether. The worker built up the patient's morale and self-confidence by frequent interviews, helping her to recognize her own capabilities and to look at her handicaps in an objective manner. She helped the patient find a good position for which she was suited, and where she carried considerable responsibility. She also aided her in adjusting to her partial deafness, which had been partly res - ponsible for her nervous breakdown. As the worker's rapport with this patient was excellent, and as there were several constructive factors on which to build, the worker was able to assist the patient to make a good adjustment to the community.

Case G represents a six-year-old girl above average in intelligence, unstable and impulsive in temperament, who was admitted to the hospital in March 1941 for 40 days' observation, and later committed. She had a history of poliomyelitis, encephalitis, and trauma. She was such a behavior problem that she was not able to get along at home. The diagnosis made was: Primary Behavior Disorders in Children, Conduct Disturbance.

When this child was referred to the social worker for placement it was felt very inadvisable to return her to her own home. The worker's visit to the home showed the mother to be a very poor disciplinarian, and the five children in the home presented almost as severe behavior prob-

lems as the patient.

Although the child was known to many agencies before her commitment it was impossible to find one which was willing to place and supervise her. After much effort a home which was felt to be suitable was found by the social worker and the child was placed, with the hospital paying the board and the social service department supervising the patient.

The home to which the patient has gone is a well-furnished, comfortable one and the foster-mother is a middle-aged, intelligent woman who has reared several children of her own, the youngest now of high school age. G-- is regarded affectionately by all members of the family and is adjusting well in the home. She attends school daily and causes no trouble. The foster-mother reports that she is sometimes stubborn and inclined to tempertantrums. However, she reacts well to punishment on such occasions, and there has been no evidence of former impulsive, destructive behavior.

For the few months this child has been in the foster home she has made an excellent adjustment. Time will be an important criterion in this case. Psychiatrists have disagreed as to whether the basis for the child's abnormal behavior is organic or environmental. If she continues her present satisfactory adjustment it will appear that

environment was, as far as evidence points, a most important causative factor and that the efforts of the social service department have been truly worth while.

The difficulty in this case was that of behavior disorder and conduct disturbance, and was met by changing the environment of the child. She was placed in a foster home where she was the only small child, and was the center of attention. She was with foster parents who understood children, and had brought up their own successfully. She was placed in a different school and neighborhood, to give her a chance to develop where her previous behavior would not be a handicap. Although she was sometimes stubborn, and inclined to temper tantrums, her behavior was considerably improved both in school and in the home environment. Considerable case work will have to be done with the family of the patient before her own home will be suitable for her to return to them, and it is planned that she will remain in the foster home until that time.

Case H shows a 58-year-old married woman admitted to the hospital in June, 1939, and diagnosed Psychosis with Syphilitic Meningo-Encephalitis, General Paresis, Paranoid. This patient had been intemperate for several years, and had trouble with her husband, who sought her admission. In December, 1940 she had improved sufficiently for a trial outside the hospital.

The patient's husband denied that he knew of her syphilitic infection prior to her hospitalization. He became very much incensed on learning about it, stated that he would have nothing to do with the patient, and wanted her to remain in the hospital. He was finally made to realize that the doctors felt she was well enough to get along outside of the hospital, but he refused to cooperate in any way. Her parents were dead, but an interested brother and sister were willing to visit her occasionally, although they could not offer her any financial assistance or help in finding employment or a place to live.

The patient was much upset over her husband's attitude, and felt it unfair since she had been a good wife and had given him all her money to set up a tavern business. After many interviews the patient became less discouraged and agreed to start life anew without help from her husband. Through the aid of the worker a pleasant room was found for her and employment as a sewer in a local factory. She reports to a weekly clinic for luetic treatment and has made an excellent adjustment in the community. She has had a few upsetting episodes. For instance, having to apply to the Legal Aid Society for supplementary financial help from her husband upset her, and on one occasion she caused a little disturbance at her husband's tavern by warning a waitress, who she said was living with her husband, to stay

away from him. On each occasion the worker aided the patient in regaining her stability and she has come to seek advice and encouragement from the worker regularly.

This patient, who has been out of the hospital almost a year and is about to be discharged, has become as well-adjusted as could be expected. Her living quarters are immaculately clean, well-furnished and decorated with samples of her crocheting. She is always neatly and tastefully dressed. She works regularly, manages well, gets regular anti-luetic treatment, and is no longer bitter towards her husband.

Possible causative factors in this patient's breakdown included personality factors such as an unstable temperament and a difficult-to-get-along-with, suspicious make-up; a physical disease, syphilis; subnormal mentality; intemperance; and marital friction. Possible constructive factors on which to build the patient's adjustment included her ability to keep a position, and to manage her affairs thriftily. As her husband refused to take her back after her release from the hospital, the worker helped the patient meet her needs by finding her a room in a boarding-house and getting her a job. The worker visited the patient frequently, giving her advice and encouragement regularly, and the patient was enabled to maintain herself in the community as a happy, well-adjusted member. She

obtained medical treatment weekly, visited her brother and sister often, and kept away from the husband who did not want her.

Case I shows a 33-year-old married man admitted to the state hospital in 1939 because he was depressed. He was not doing well in his business, and was in poor physical condition as a result of continued drinking.

This young man with high average intelligence and a good school and occupational record, had a history of increased alcoholism for ten years. His emotional conflicts centered around his diminished capacity for work, with consequent economic insecurity and inability to provide an adequate home life for his wife and two children. He was considered a successful portrait painter until the depression, but for 18 months prior to admission to the hospital he had been working for the Works Progress Administration. He had recently had trouble with his eyes, which caused him to lose even this employment and to apply for relief.

In spite of his drinking, which was partly due to the artistic circle of which he was a member, he was a surprisingly stable type of personality. He recovered from his mental symptoms, and in March 1940 he was released on visit to his wife, who had been a patient in the same hospital. His diagnosis was: Alcoholic Psychosis, Korsakow's Psychosis condition improved.

The social worker referred both the patient and his wife to a welfare agency, for special consideration. In order to insure optimal improvement in both cases, it was suggested that additional allowances be considered for proper treatment, which consisted primarily of rich diet with additional vitamins. The man's eyes were examined by a specialist, who reported there was nothing of any objective significance in the examination of the eyes. With a high vitamin, high caloric diet, the man's physical condition and also his eyesight were so greatly improved that he was able to return to work on a project and to support his wife and two children until his sudden death in an accident in February.

Possible causative factors in this patient's breakdown included a physical handicap of poor eyesight due to drinking, increased alcoholism for 10 years, the loss of employment because of poor eyesight and the depression, and emotional conflicts centering around his unemployment and the family's dependency. Constructive factors on which to build the patient's adjustment included high average intelligence, a stable temperament, a pleasing, sociable personality, genuine love of his wife and two children, and the fact that he had been successful in business. The worker met this patient's needs by establishing a home for the family for the first time and by securing sufficient aid for

the family so the patient's health could be built up. With better health, the patient's eyesight improved, and he was able to return to work. With his regaining his work and ability to support his family, his emotional conflicts were lessened, and neither he nor his wife returned to their former habit of drinking to excess. Thus they were enabled to make a good adjustment in the community, to become self-supporting, and to lead a normal home life.

CASE J represents a 24-year-old single man admitted to the hospital in 1941 because of brooding over a love affair, difficulty with the police, nervousness, and talk of suicide.

This patient was graduated from grammar school at the age of 15, having repeated two grades because of asthma. He was of dull normal intelligence, and was quiet but fairly sociable. He had only one serious love affair. The girl was working at the time and he was not, so he finally stopped seeing her, and this upset him, especially when she became engaged to another man.

Because of the patient's accosting a girl, the family had their first contact with the police, and they were all very upset. The patient happened to see a girl he knew slightly, went up to her, took her arm, and asked her where she was going. She was startled and started shrieking and ran away. The patient was arrested, and later sentenced to

serve two months in an institution. He had some trouble there, and was admitted to the mental hospital, where a diagnosis was made of Dementia Praecox, Simple Type. After four months, he was released to his parents.

This patient had a physical handicap, asthma; sexual difficulty with a girl; an arrest; dull normal intelligence, and only a grammar school education. He was the fifth of six children in an exceptionally respectable and closely-knit family. The social worker met his needs by giving him and his family some understanding of his illness, by encouraging the patient to get a job which he held for several months, by advising him to join organizations and helping him find recreation, by helping him to feel that his family approved of him, and in other ways adjusting him to his environment.

Case K indicates a 45-year-old married man with four small children, who was admitted to the state hospital in 1937, because of a suicidal attempt made after drinking. It was later discovered that he had had two severe head injuries for which he had several partially succesful operations, and also ulcers of the stomach, and that he had not begun to drink much until after the accidents.

This man, a grammar school graduate, worked as a conductor for 24 years. Before the accident, he was prosperous, and had a beautiful home. He was kept on his job

for a short time after the accident, but one day he took a bottle of liquor out of his pocket and proceeded to drink in front of all the people on the car. He then drove to the station, where he was suspended and later dismissed. The family lost their home and all their possessions and were, therefore, aided by the relief agency.

As a young man the patient was a pleasant person, fond of his family and sociable at home, but he did not mix with his fellow-employes. He was described by his wife as being very egotistical and self-centered. There was a personality change after the accident. The patient became very irritable and difficult. He made a great many attempts on his life, and threatened to harm his wife and children because he could not take care of them.

After four years in the hospital the patient had improved sufficiently to be tried on visit, and was released to his wife. The day after his release, the wife became ill and was sent to a hospital, and it became necessary for the patient to stay home to care for the children. Two months later, after his wife had returned home and was again able to care for the children, the patient asked social service assistance in obtaining work. He had made several applications to work for his former employer, but did not feel able to work full-time. His former boss advised him that he still seemed nervous and was better off

with the Aid to Dependent Children which the family were receiving, as he had a steady income. The patient's ulcer trouble had recurred, and his doctor advised his not working at the time. The social worker was able to persuade him that it was for the family's best interests for him not to work at the moment, but assured him she would help him to secure work as soon as he felt able to work full-time.

Later, when the patient felt able to work, he came to the hospital for a physical and mental examination, for which the worker arranged, and to discuss employment with the worker. He asked for assistance in persuading his former employer, the street railway company, that his drinking on the job was due to his illness, and that he had recovered and was well enough to work. This was a difficult undertaking, as the company had rules against re-employing men who were known to drink. It required interviews with officers of the company, with the union delegate, and with other social agencies actively interested in the family. It was felt that the patient needed work sorely, not only economically but also from a therapeutic angle, and he was finally re-instated. During this period the worker had interviews with the patient and his wife, to help them to a better understanding of the situation.

In this case the liabilities included: the physical handicap of ulcers of the stomach; very severe brain surgery;

a tendency to drink; a tendency to suicide; and partial dependency. The assets included the fact that the patient was of average intelligence, and had two years' high school education; he was happily married with four children of whom he was fond; he had held one position for 24 years; he was very persistent in trying to help himself.

The social worker helped the patient to meet several of his problems by using the resources in the community, and helping him return to his former employment. After a long struggle with many influential people, she secured the patient's former position for him. Thus the worker helped the patient to become self-supporting again, to gain back his self-respect, his pride in his work, and his independence. This made his married life much smoother, as his wife nagged him much less when he was working and had a regular income. The patient became less nervous, had less stomach trouble, was much less irritable. He made a good adjustment to his work and home.

Two cases presented special sexual problems. Case L is that of a 19-year-old boy who was an exhibitionist and boasted of his love affairs. Case M represents a young woman with an illegitimate child.

Case L shows a 19-year-old boy who attempted to stab an officer with an ice pick soon after enlistment in the army. The same evening he threatened suicide and struck

his head against the cell wall. After being hospitalized, he continued to act in a peculiar and unusual manner, and was finally admitted to the state hospital in September 1940.

This young man began having trouble in school in the fourth grade when he was 11 years old. He was referred to a psychiatric clinic because of excessive forgetfulness, poor school work and day dreaming. His room teachers considered him very childish. He made constant bids for attention, laughing or crying easily. He became more seclusive and sensitive. He suffered from fear reactions. He failed in all eighth grade subjects. He was placed in a foster home in 1937, but was expelled from school because he stabbed another boy with a pair of compasses. He got into fights continually. He was noisy and an exhibitionist. In 1938 he was sent to continuation school where he continued to be difficult, threatening the other children with a knife and boasting of his sex affairs.

The case was referred to the social service department for home investigation.

The patient's family was anxious to have him return to his former home, but after investigation by the social worker, the psychiatrists felt that the patient's psychotic behavior was a result of his environment, and that only in a carefully selected environment could his personality pattern be moulded in such a way as to allow him to take his place

again in society.

After much effort, a farm home was found about 25 miles from where the patient formerly lived. The family were of the same racial and social background as the patient, and there were two sons near his age. Through therapeutic sessions, the patient was given some understanding of the factors governing his social behavior, and he was anxious to co-operate with plans made by the hospital. The patient was seen by the worker every two weeks and over a six-month period has made an excellent adjustment. He has shown an increasingly genuine interest in farm activities and has shown much initiative in making repairs about the place. He does an excellent day's work and performs all chores cheerfully. The caretakers report that at no time does he react to frustration by any display of violence. At present, he is a good-looking, physically fit, apparently well-adjusted young man. He expresses no desire to return to the city.

This young man had been a behavior problem since the age of 11 , with amoral and asocial trends, and it was felt by the psychiatrists that his mental illness was largely the result of his home environment. When he was improved sufficiently to be tried outside the hospital, the social worker met his needs by placing him in a different environment, which was carefully selected. In his new surroundings he lived in the country rather than in the congested area of a

large city. Instead of doing factory work as before admission, he became a farmer. He remained in close contact with his own family by frequent visiting, but made a good adjustment to the farm home. His mental and physical health improved, and he was no longer a menace to society.

Case M represents a 26-year-old, single, Polish woman admitted to the hospital in February 1940 following the birth of an illegitimate child. She had seemed mentally normal before the birth, although she was alone during most of the pregnancy, and did not tell anyone about it for several months.

This patient was the fourth of nine children. Her father died when she was quite young, and her mother was a patient in a state hospital most of the girl's life. The patient was brought up in an orphanage, where she attended school, completing the eighth grade. She was very much in love with a boy of her own race and nationality, and planned to marry him, but both families asked them to wait a while. After the birth of the baby, the patient refused to talk and sat staring into space. She seemed to worry about what was to become of the baby, became mentally ill, and was admitted to the hospital.

After three months, the case was referred for home investigation by the social worker, as her two sisters were extremely anxious to take the patient out of the hospital.

She needed constant, intelligent adult supervision as she was still acutely psychotic.

A home visit showed that the house was neat and clean, the rooms were nicely although simply furnished, and the home atmosphere was pleasant. The family consisted of two sisters, both single. The older, aged 33, was a graduate nurse who was constatly employed on private duty. She was an intelligent woman who seemed to have an unusually good understanding of the patient and the problems she would have to face when she left the hospital. This girl brought up the younger children in the family. The other sister was 25 and a waitress by occupation, unemployed at the time. She appeared intelligent and mature, had a sunny disposition, and a good understanding of the patient. The other siblings were living elsewhere. The two sisters seemed devoted to the patient and to each other. They were determined to see that the patient did whatever was best for her future adjustment and happiness. They had two very close friends who were also interested and would help with the patient's care and supervision when she was out of the hospital. They planned to place the baby in a boarding home supported by the father, who admitted paternity but absolutely refused to marry the patient or to have anything to do with the family.

The worker felt that the patient's family were unusual-

ly intelligent and competent, and well able to care for the patient. The sisters realized the dangers involved and had made plans to deal with them. They desired to take the patient out for very short visits at first, and were allowed to do this. After a month, the patient seemed well enough to be tried on a year's visit.

The social factors in this case included virtual orphanage at an early age, as the mother was psychotic and placed in a state hospital, and the father died when the patient was young; institutionalization of the patient from the age of eight to 16; the patient's giving birth to an illegitimate child before admission. On the other hand, the patient had average intelligence, an eighth grade education, a pleasing personality. Above all, she had two sisters and two friends who were devoted to her and had a good understanding of her mental illness and the problems relating to the illegitimacy of her child. They were interested, intelligent and cooperative, and anxious to have her in their home. The patient reported to the out-patient department regularly, and was also supervised by the social worker in the home. After eight months in the community, she is apparently well mentally and well-adjusted emotionally. She has worked steadily in the packing room of a large concern for the past six months, and is doing well at her work and at home. The baby has been accepted by the sisters and is now living with them and the

patient, who is devoted to it. The social worker helped most in this case in the pre-parole period, in helping the patient's family to have an understanding of her illness, and in preparing the way for her to go home; also in guiding the patient following her release.

Cases N and O may be called problems in social relationships. N is the case of a young woman who does not have enough socializing activities, and O represents the case of a widower who imagines people work on his mind and are against him.

Case N shows a 27-year-old single woman who worried so much about her brother, who had been sentenced to a penal institution for stealing cars, that she became quite ill and was committed to the state hospital in June 1940. This young woman had had an unsatisfactory home life. Her father died when she was an infant, and her mother had to work to support the two children, and left them to their own devices when the patient was 14.

The patient's mother was willing to take her on release from the hospital, but the patient was unwilling to go, since she had been separated from her mother for several years. She seemed to lack mother-love and respect for this parent. She had formerly been employed as a domestic, but she felt the long hours were too strenuous for her physical condition, and desired work as a waitress.

A room was found for her and, with the aid of another social worker, a waitress position in a respectable restaurant was secured.

After five months, the patient is still not entirely well. She is seclusive, somewhat suspicious of those who are trying to help her, and unwilling to confide her difficulties to anyone. She is seen weekly by a worker and needs the encouragement and advice she is given at these times. The patient shows some inability to make decisions and some tendency to capitalize on minor physical complaints in order to stay in bed and remain away from her work, but with prodding and encouragement, much ground is being gained.

Had the patient been unsupervised, she probably would have given up long ago and been returned to the hospital. She will need supervision and help for a long period.

It is hoped that she can be interested in more socializing activities, but at present, she is self-supporting, caring for her wants adequately, and is interested in reading, knitting, and church services. On the worker's last visit, the patient showed some interest in establishing a home for her mother, whom she had begun to visit, and for her brother, who was recently released from the penal institution where he had been for several months.

This patient's problem was to make an adjustment outside the hospital, and was met by finding a place to live,

securing employment for her, and giving her encouragement and advice in the matter of making decisions. She is now self-maintaining, and has some outside activities. The chief difficulties now are that she needs more socializing activities, will require supervision for a long period, and will have to come to some decision as to whether or not she should establish a home with her mother and her brother, with whom she has not lived for 13 years. She has not been in sympathy with her mother and her brother worries her because of his bad habits. Although she is still not entirely well mentally, she has made considerable improvement in her mental health, is more stable emotionally and better adjusted socially than when she was first released on trial visit under the care of the social service department.

Case O is that of a 65-year-old widower with no children, admitted in 1915, and diagnosed Alcoholic Psychosis, Other Types, Chronic Hallucinosis. He was quite depressed on admission, and said he heard voices continually. He thought that people worked on him through his mind. He admitted excessive drinking and "imaginations", and considered they were due partly to his wife's committing suicide six months after their marriage.

For several years in the hospital, the patient was emotionally dull and indifferent. He had ideas of persecution, but seldom expressed them. He was an excellent

ward and dining-room worker.

As far as outside friends or relatives were concerned the patient was a forgotten man after 26 years of hospitalization. He had been working faithfully and well in the hospital for many years, never complaining, and almost ignored.

When the possibility of his leaving the hospital was suggested by the social worker, the patient was overjoyed but discouraged since he felt he had no one to go to or help him. After the worker's assurance that she would assume that task, the patient and she worked out plans for his release which included finding a job and a place to live

Employment was found which was very similar to what he had been doing for years in the institution, and a room was located with a man who had also been a hospital patient. The two men knew each other and got along well. After four months in the community the patient has made an excellent adjustment and seems genuinely happy. He is cooperative, answers questions relevantly and coherently and shows no abnormalities of mental content. He is steadily employed, has a comfortable room and enough money to care for his needs, and has shown no tendencies to revert to liquor since leaving the hospital. In the past month he has been spending his spare time visiting friends, and has enlarged his social contacts. Thus after 26 years in a mental hospital, he is again earning his living and is a well-adjusted man,

living a normal life in the community.

Weaknesses in this case include-- hospitalization for 26 years, thus losing contact with the world; a lack of any ties or friends outside the hospital; the loss of his wife by suicide soon after marriage; alcoholism. The strengths include good work habits, normal intelligence, and a stable temperament. The social service met this patient's needs by helping him to find a job and a place to live with men from the hospital, who could help him adjust to the outside world. The social worker recognized a patient who was lost in the institution and who had possibilities for self-maintenance, a man who was forgotten by the outside world. She helped him to earn his living, to get along in the community in a satisfactory manner.

The five remaining cases exhibited marked personality or emotional problems (Cases P,Q,R,S,T). All of the preceding cases manifested personality difficulties but seemed to have other accompanying problems, physical or environmental, lacking in these case histories.

Case P represents a 41-year-old widow with one child, admitted to the hospital in 1937 because she imagined that social workers were hiring persons to spy on her, and using trained dogs, machine guns, and bombs on her. This patient was a native-born woman of Lithuanian descent and Jewish religion. She was not very good-looking and not popular

with the opposite sex. At 21 she married a peddler, a peculiar sort of person who left her, remarried, and settled in Palestine. One son was placed in a state school not so much because of feeble-mindedness as because he was a behavior problem. The patient was brought up in a strictly orthodox home, and had great sex conflicts after marriage. Her emotional reaction to her home situation and her peculiar behavior led to her commitment.

For many years prior to admission the patient had complained of all sorts of aches and pains with no physical basis, and the condition was apparently hypochondriacal and an effort to gain attention and spend her time. She was always a difficult person to get along with, as she was very egotistical. She was never willing to do her share of work in the household, and felt she should be given everything and contribute nothing. Her diagnosis was Paranoia and Paranoid Condition. After three years in the hospital, she was referred to the social service department for home investigation and trial visit.

Placement of this patient outside the hospital was a difficult one because her relatives, who were brighter than she, were ashamed of her and did not want her with them. The patient was a low-grade moron who barely managed to reach the ninth grade in school after repeating several grades , and was never considered bright. She had a difficult per-

sonality-- demanding, egotistical, never willing to do her share. Her hypochondriasis, which was apparently an outlet for her emotional energy and an effort to gain attention, made her unwelcome in her relatives' homes. The patient realized her inferiority and was jealous of her married sisters. She was quite harmless, and very persistent in her demands to be released from the hospital. The doctors felt that she could make an adjustment outside, with adequate supervision, and that she should be released.

The social worker helped the patient and her family plan for her leaving the hospital. A home was found with a distant relative, in a town away from most of her relatives, where the patient could be boarded for a modest sum. The relatives, who were cooperative in making plans, agreed to contribute to her support. The patient found wholesome recreation, and was kept busy about the house. She reported to the worker at the hospital every week, when her difficulties were discussed. Thus the patient was enabled to live in the community comparatively peacefully. She became more compatible with her environment, and quite a pleasant person. She improved so much that the relatives did not object to her making them short visits, and a brother offered her a home with his family.

Weaknesses in this patient included her low intelligence, her emotional instability, hypochondriasis, and

feeling of inferiority; also her personality-- egotistical, difficult, demanding. The strengths in the case included the closeness of the family ties even though the other members had little understanding of the patient's difficulties at first, the patient's persistence, and good physical health. The social worker helped the patient meet her needs by finding her a place to live, enlisting the cooperation of relatives to support her, keeping the patient busy, and finding her wholesome recreation. The worker also gave the family some understanding of the patient's problem, and enabled the patient to live happily in the community.

Case Q is that of a 39-year-old single woman with a history of mental illness in the immediate family, as her sister and father were both mentally ill. She was admitted to the hospital in 1939 because she was restless, depressed and thought she was going to die. The precipitating cause was the menopause, and the diagnosis, Psychoneurosis.

This patient had been a slow pupil. She completed eight grades in grammar and night school, but interest in studies was lacking, her marks were poor, and her behavior bad, due for the most part to her stubborn attitude and bad temper. She had borderline intelligence with an I.Q. of 77. She had had severe temper tantrums all her life, at which times she would strike her sisters.

The patient had one serious love affair at 19, which

deeply affected her attitude for the rest of her life. Disappointed in this affair, she had eyes for no other man, but continued to cherish the memory of the first.

She did unskilled work, for the most part working in a factory for 15 years, when she was discharged through no fault of her own. After her discharge, she worked in households for a short time, but displayed no ambition and was inefficient, although her efficiency was not lacking during her factory years.

She was a poker-faced individual, was bashful in the company of strangers, and in fact, shunned new-comers. She preferred solitude, and was extremely hard to get along with. She had gloomy spells, distrusted everyone, and was suspicious. She worried a great deal about her love affair and was conscious of a sense of insecurity, for she had no means of earning her own living, and realized that she was dependent upon her brothers and sisters, none of whom were working.

When she was ready for release, there was no member of the family who was willing to take her. Consequently she was placed with an understanding caretaker at the hospital's expense, her sister to supply the clothes.

When first visited the patient appeared happy and contented. She assisted with the housework, and took frequent walks with a member of the caretaker's family. Her sister

kept in contact with the patient, who considered her stay in the country as a vacation. Later the patient became discontented and resented the foster family's supervision. She was placed in another home to learn to be a domestic, and was paid a small sum. This pleased her better, but when her sister became ill and in need of help, the patient went to live with her. The sister lived in a pleasant, well-cared-for flat in a respectable neighborhood. The patient did the housework during the day and attended school in the evening, taking cooking and advanced English so that eventually she might be independent. The patient seemed to be getting pleasure and a sense of accomplishment from her school work, and to make a satisfactory adjustment.

This patient's weaknesses included borderline intelligence, grammar school education, dependent economic status, difficult personality, unstable temperament, and no close family ties. The social worker helped her meet her needs by finding her a home, helping her to learn to be self-supporting, aiding her family in accepting her, and finding her wholesome recreation and an opportunity to further her education. Though she was still somewhat irritable and subject to fits of depression at times, she continued to improve in these respects.

Case R represents a 32-year-old married woman first admitted to the state hospital in 1935, after being picked

up by the police who thought she was drunk. She was giving a long monologue in a cafe, on the greatness and bravery of the world war veterans, and singing the national anthem in a boisterous manner. After a few months in the hospital she was released on trial visit to her husband, diagnosis Manic Depressive Psychosis, Manic Type, condition improved. Within a four-year period she was released and returned nine times, and the story was about the same, with minor variations. She would find a position, and for some reason such as being late to work, would lose it. She would get into a scrape such as pawning an unpaid-for coat, and be picked up by the police. Becoming so over-active that her family found it difficult to supervise her adequately, she would be returned to the hospital, where she would remain a few weeks or months until she calmed down and was again released.

At present she is on visit from the hospital. Because of financial and other conditions, she lives with her family, the husband lives with his relatives, and four of the children are boarded in private families, one child remaining with the patient's mother.

This attractive young married woman is a stenographer of high average intelligence who shows emotional conflicts centering around her family relationships and economic insecurity. She is the oldest of ten siblings, all of whom

except the patient have made a fairly good adjustment. Her married life has been one of friction. She is now separated from her husband, a shell-shocked World War veteran who has caused her great unhappiness because of his nervousness and alcoholism, and consequent failure to provide an adequate home for her and for their five children. The patient also has conflicts about the children. While she is confined to the hospital, she begs to be allowed to see them and tells how brilliant they are. When she is released, she spends the money she earns on herself, not the children, and does not visit them frequently.

Her instability of personality has caused her to lose several positions commensurate with her intelligence and ability, and in which she achieved some measure of success. She is now employed in a position which does not require much skill, and is looking for a better one. Her pleasing manner, good appearance and intelligence are assets in obtaining employment, but her instability and insecurity keep her from holding a position long enough for advancement. These emotional handicaps also prevent her making a satisfactory adjustment for long outside the hospital. At the present time, however, she has been out of the hospital several months, is still employed and has the offer of a better position, and has taken more interest in her children.

This patient's chief problems are an unsatisfactory home life and emotional instability. The patient does not wish to return to her husband at the present time, but has some desire to make a home for her children. The worker is helping her to meet this difficulty eventually by aiding her in finding employment in order to support them, and by steering her to other social agencies who may be able to assist her. She has become more stable emotionally, although there is no great change in her personality. In this case social service supervision has helped the patient stay out of the hospital longer than she would otherwise, and to make a fairly satisfactory adjustment in the community. The worker helped the patient not only with her employment and financial problems, but tried to give her some understanding of her illness and of her emotional handicap. The worker supervised the patient on visit to aid her in solving any new problems which might arise.

Case S is that of a 38-year-old married woman, admitted to the state hospital in 1939 for 40 days' observation, and later committed. She had one previous nervous breakdown before marriage. Admitted because she was annoying others by constantly telephoning to them, and hanging up when they answered, she was suspicious of everyone. She also had a number of somatic complaints with no known cause. After several months' residence in the hospital, she was

released on visit to her father. The diagnosis was Dementia Praecox, Paranoid Type, condition improved.

She is a young Jewish woman of normal intelligence, showing emotional conflicts centering around not only the relationship with her husband, but also, primarily, the frustration of being separated from her children. Both the patient and her husband are emotionally unstable, but hers is the stronger, more aggressive personality, and she tries to dominate her husband, who is more passive and also neurotic. The patient has always been nervous, suspicious, jealous, and dissatisfied with marriage. She blames her husband for being admitted to a tuberculosis sanitarium eight years after marriage, and because the children later contracted the disease . She reproaches him for his lack of success in finding work, with the family's consequent economic insecurity. She resents having to live with her father and siblings while he lives with his family, and the children are boarded in foster homes. Her ambivalence in her feelings towards the husband may be illustrated by the fact that when he was released from the tuberculosis sanitarium in 1938, it took her ten months to find a house to live in. This was in spite of the fact that, due to her constant and insistent demands for a home, a private agency had promised to help the family financially to re-establish one.

Since the day of her release from the hospital, this patient has talked of making a home for her two young daughters, either with or without their father. They are in an excellent foster home, but she finds considerable fault with it. She professes to be very fond of the children, but continues to interfere with their care in every conceivable way. She is constantly complaining, and doing everything possible to disturb their relationship with the foster mother. Although the custody of the children has been granted the husband and the child-placing agency, she refuses to accept the decision of the court, which she considers most unfair.

This patient had many problems, including a readjustment outside the hospital after a severe mental illness, the decision to get along without her husband or to return to him, and adjustment to the fact that the children were placed in a foster home by order of the court and that it was impossible for them to return to her at the time of her release from the hospital.

Social service supervision in this case has helped the patient make a partially satisfactory adjustment outside the hospital. After holding several positions for short periods, she is again working in her previous occupation of bookkeeper, and has become economically self-maintaining. She is much happier when employed, and causes less

disturbance on her weekly visits to her children. She continues to live with her family, but feels she has a place there because now she is able to pay her way. She is more sociable, and enjoys attending parties. She has joined clubs and is learning to play the piano in order to entertain her friends. She is still quite concerned about the difficulty of getting the children home, and is planning for the time when she is discharged from the hospital, and the children may be returned to her. Although she is still fighting for them, she causes less disturbance on her weekly visits, is less aggressive and less frustrated, and is better adjusted emotionally than when she first left the hospital.

Case T represents a 75-year-old woman, twice married and divorced, with one son. The son is said to have actively hated his mother since her public declaration, "Is that ugly boy mine?" The second husband left the woman in 1904, and since that time she has lived in the same house with her son, but in very different parts. The woman lived in a sub-basement in a dark room with her dishes on the floor in one corner, some cosmetics scattered over a bench near the floor, her cot in one corner and her clothes in another. The closet was filled with old pieces of carpet full of moths. The son occupied a room on the fifth floor. The rest of the house was dirty and run down, almost dilapidated.

This woman had had a series of arrests for carrying a

loaded revolver, and for conducting a house of ill fame. The patient had always fought with both her husbands, and continued to fight with her son. When they were together the friction was tremendous. It would start over some trifling thing and mount to a sort of explosion, which stopped just short of violence, if someone was present.

The patient owned several houses which were heavily mortgaged. She employed a second lawyer because she thought the lawyer who had taken care of her property for years was not fair to her. The lawyers agreed that should a conservator be appointed by the court, the patient would get little or nothing from the property she owned because it was so involved and troublesome. They felt that if the son were appointed guardian the patient would carry on as usual. The second lawyer withdrew, and the first lawyer was glad to act in an advisory capacity as before. He felt that mother and son should be separated as far as living went because they reacted so vigorously to each other that violence might well be the outcome.

In June 1941 the patient was referred to the social service department for home investigation and release on trial visit if suitable arrangements could be made. As a result, the patient was released in the care of a friend, and her son was appointed temporary guardian. Very soon she broke into her own house, and created some disturbance

about the appointment of her son as guardian. The worker visited the patient to explain to her that she would have to return to the hospital unless she behaved herself.

When in the home of the friend to whom she was released the patient occupied a large rear room flooded with sun - light and immaculately clean. There was a small kitchen - ette attached to it. The patient, when visited, made a very good appearance and talked rationally although volubly. Later, she became dissatisfied with this arrangement, fought with her friend and lawyer, and took a room elsewhere. She threatened to sue the lawyer, her son and the hospital.

The son paid her board, and gave her money for clothes, but she went around looking like a tramp. The mother and son were getting on fairly well because they were living apart and saw very little of each other.

On a visit to the patient's new address, the worker saw the landlady, a friendly Irishwoman, who seemed interested in the patient. The patient had a back first floor room with a kitchenette which contained a stove, sink and ice chest. The room was adequately and comfortably fur - nished, and fairly clean. The patient did not appear as tense as when last seen in the home of the friend. She said she lost weight in her previous room, but was now eating properly and gaining weight.

This patient is a great talker. She expresses no ani-

mosity towards her son, or any desire to be with him or have him live with her. She seems mildly resentful that her son is holding down a job for the first time in many years. She has kept busy putting her affairs in order, which she said "went to pot" while she was in the hospital.

The patient seems to be looked after adequately, and her present environment seems suitable. The clothes she wears are no more odd than the clothes of many women in that district. The patient has always been peculiar about the way she dressed and will probably continue to be so.

This is a case in which the rather brisk personality of the patient is likely to create reactions from her environment; consequently, frequent supervision is advisable. The patient's son is in touch with the lawyer, who telephones the worker regularly, and keeps the hospital aware of what is going on. The patient is not creating a disturbance in the neighborhood where she is now residing, and is not, as formerly, drinking wine to excess.

This patient was a problem in many ways. Her temperament was unstable, her personality maladjusted. She had a violent temper, was eccentric, possessive and jealous, and had nervous screaming attacks. She was ruining the life of her son, and was unable to get along with anyone. She had physical handicaps of age, general arteriosclerosis, and heart disease. She was alcoholic, and had been in very

serious trouble with the court. Social service supervision helped her to remain in the community with the least friction, and to be fairly happy. Placing the patient in the care of an understanding landlady and away from her son changed her environment sufficiently so that she lived in a more nearly normal environment, and she was no longer a menace to others.

Part V

SUMMARY AND CONCLUSIONS

The findings with regard to social service supersision of patients released from the Blank State Hospital during 1940-1941 may be summarized briefly. All of the 20 patients studied were white; 13 were female and seven male. Seventeen were native-born, and three foreign-born. Eight were single, three married, four widowed, four separated, and one divorced.

Nine of the patients stayed in the hospital prior to release on visit less than one year, six between one and two years, and five over two years. The ages of the patients at the time of release were widely scattered from six to 75 years, and the median age was 36 years.

Five of the patients had a common school education or less, seven had some grammar school education, and seven attended high school. One took courses beyond high school. Thirteen patients ranked average or above in intelligence, seven low average or below. The highest I.Q. recorded was 137 and the lowest was 65. Only five pa - tients had court records before admission, and none had records for offenses committed following release.

There was a great variety of medical diagnoses, and 13 of the 20 patients had 13 diagnoses. There were six

cases of Dementia Praecox, four of Alcoholic Psychoses, and three Manic Depressive Psychoses. These were the leading diagnoses in all the hospital cases admitted during the year.

From examination of the cases presented it may be seen that the function of the hospital social worker is not primarily giving relief, placing children in foster homes, or doing family case work when other agencies are available for these services.

> Family problems which are her function are those caused chiefly by the illness of the patient. The hospital social worker assumes the major responsibility working these problems out, using resources, reconciling the family to the patient's illness, and helping them work out plans. She also has an important role in problems of an emotional nature, in the adjustment of the patient's family to the patient, and in working relationships between the hospital and community.... The understanding handling of the social factors which seem to have contributed to the patient's illness is the primary function[1] . . .

of the social worker.

To assist in understanding subsequent discussion of the role of the social worker in these 20 cases the functions of a psychiatric social worker in a state hospital have been summarized according to the Committee on Psychiatric Social Service of the American Psychiatric Association.

1. To study case situations and complement the examination by the psychiatrist.
2. To effect changes in the environment involving the patient or case situation and to this end familiarize herself with all public and private social wel-

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1 Crutcher, op.cit., p. 26

fare and educational facilities in the district in which the clinic or hospital operates.

3. To secure the cooperation of other social agencies and when possible to arrange for them, through joint conferences with the psychiatrist, to work cooperatively with the hospital or clinic.

4. To effect changes in or modify attitudes of patients, and more particularly their relatives, in order that changes in the environment and the advice of the psychiatrist may be accepted and followed regarding their attitudes and activities as related to the problems in the case situation.[2]

The 20 cases presented in Part IV (Cases A-T) have been studied intensively, as to the difficulties presented by the patients, and an evaluation of the social work involved. The situations of the patients under supervision were many and varied. Each patient had more than one problem, and most of them had several major ones. All had the handicap of mental disease, either chronic or temporary; and six presented distinct health liabilities, such as asthma, brain tumor, ulcers, poor eyesight, syphilis, all of which interfered with the patients' adjustment. (Cases F,G,H,I,J,K). Two were troubled with special sexual difficulties (Cases L,M). There were seven legal cases, including problems concerning property or support, and those resulting from the conduct of the patient or of others.

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2 American Psychiatric Association, Report of the Committee on Psychiatric Social Service, American Journal of Psychiatry, 13 (90 old series): 434, September 1933.

Personality or emotional situations were always present. There were 13 patients who were very unstable temperamentally, 10 with anti-social habits (the majority of these alcoholic) and 9 with vacillating interests. (See Cases P,Q,R,S,T).

As for educational difficulties , 15 patients needed help in readjustment of habits of mind, and nine at least had handicaps associated with recreation and social relationships.

All the patients had problems connected with the environment, and these may be classified as follows: nine had marked financial difficulties, and seven had employment troubles. Nine were living in unsuitable surroundings, and in seven there was family friction, in five cases marital friction. (For the special environmental problems, see Cases A,B,C,D,E).

To summarize, all the patients suffered from some mental disease, all required readjustment to the community following their hospitalization for mental illness. They all had more than one difficulty besides the mental disease and these problems included emotional, social, and environmental adjustments. As shown in the cases cited, the social worker was able to help these patients live in the community under supervision, and in many cases to be self-main-

taining, thus enabling them to reach the major objective-a better social adjustment for the patient and the highest degree of self-direction, independence and self-maintenance of which the individual is capable in his environment.

First, the worker studied the case situations by securing social histories, making investigations of home and family difficulties, and making pre-parole investigations. Second, she effected changes in the environment involving the patient or his family (Cases A,B,C,D,E). The various situations revealed unsuitable surroundings, family friction, marital friction, financial difficulties and employment difficulties. These problems were met in some cases by changing the environment of the patient by placing him in a boarding home, or by securing a position for him. In other cases the social worker secured cooperation of other social agencies, such as child-placing, family welfare and public welfare agencies, for assistance particularly with financial difficulties where the income in the family was insufficient.

In several cases, the occupation and economic status had improved. The cases in which the occupation or economic status remained about the same were briefly as follows: 1) the 75-year-old woman continued to live by the rental of her property; 2) the married woman stenographer

was found another position in an office; 3) the laborer who received some welfare aid prior to admission continued to do part-time work, which was supplemented by relief from a public welfare agency; 4 and 5) two students continued their studies after leaving the hospital, but in different surroundings; 6) a woman bookkeeper before admission returned to her former occupation after release; 7) a married woman who had never been employed outside the home remained dependent on her family, with whom she lived.

The economic adjustment of ten patients improved. A woman who was unemployed and dependent on relatives and social agencies is now employed doing housework. A former dietetics and physical hygiene teacher is now on the staff of a settlement house, and has complete charge of purchasing and preparing the food. A man who had been a patient in the hospital for 26 years, where he performed laundry work for which he received only maintenance, became a worker in a cafeteria, thus supporting himself outside the hospital. A painter who received some financial aid before admission, became self-supporting, and was able to support his wife and two children. A young man who had never worked except as assistant janitor to his father obtained independent employment as a drug-store clerk, earning more money than formerly. A young girl who had never done any

work except as a domestic became a waitress after release, and liked this work much better. A young woman who had never been employed, was found a position packing tea, and was enabled to support herself and illegitimate baby. A middle-aged woman who had been unemployed and dependent on her husband with whom there was friction and from whom she was separated, was found work as a sewer in a factory, and became independent of her husband. After much intensive work on the part of the social worker an operator for a railway obtained work with the same company, but in a different capacity due to physical illness. A young man who was never employed except in his father's store where he was not needed or happy, was found work on a farm, where he made a good adjustment.

The social worker effected an improvement in occupational adjustment in several cases. In seven cases the occupations were practically the same both before and after the patient's release from the hospital. Exceptions were two patients whose occupational or economic status had changed but had not improved. A young man who was a student before admission and was supported by relatives and social agencies, continued to be supported by others, but was too ill mentally either to return to school or to seek employment. A young married woman, who had been chorus girl, salesgirl, and clerk, and had also received some

financial assistance from a public agency while her husband was also sick, was unemployed after her release, but managed to make a good home for her husband and two children, even though for a time they required relief;and later, when the husband died, she received Aid to Dependent Children, and continued to care for her children adequately, which she had never done before.

The two patients with special sexual difficulties were better adjusted after release on visit (Cases L andM). The girl with the illegitimate baby was found a position where she could support herself and child, and, with the help of the social worker, she was understood by her sisters and welcomed into their home. The young man who had not adjusted in the city and had been a behavior problem and boasted of his affairs with girls, was helped to obtain a position on a farm where he became interested in the work, lived with understanding friends of the same nationality and social background, and made a good adjustment.

Other patients were assisted to make better social relationships. Patients with unstable personalities were assisted to make a better adjustment in the community.

In the majority of the cases studied, there was an improvement in occupational adjustment, in social relationships, in attitudes of patients and their families.

The fact that the patients remained outside the hospital for several months under social service supervision, when in several cases they would have been obliged to return otherwise, shows that social service supervision was successful. Also, partly due to social service supervision, although several patients had court records prior to admission, none of them got into difficulties with the courts while on visit.

By preparing the way for the patient's release from the hospital by a pre-parole investigation, by giving supportive treatment to the patient and his family, by manipulating the environment for the patient's best possible adjustment, by explaining the psychiatrist's recommendations to the patient and his family, by cooperating with community agencies interested in the family, by helping the patient to become adjusted to the community- friends, school, employers, agencies - the social worker aided the patient to reach his goal, and to make the best adjustment possible in his environment. The psychiatrist could hardly be expected to work in this way with the patients. The social worker is the only member of the hospital staff who works with the patient and his family in their own environment. It would have been difficult if not impossible for the dietetics teacher to obtain a position commensurate with her skill outside the hospital, without the help of

the social worker. Several of the patients did not have a knowledge of community resources to help them in obtaining positions.

The psychiatrists in a busy public hospital do not always have the time to explain their recommendations to the families, and certainly not to see that these recommendations are carried out. This is the task of the social worker. Without this explanation, the families do not understand the patient as well as they should and therefore do not help him as much as they could. Though the psychiatrist works with the patient in the changing of attitudes, while the patient is in the hospital, it is partly the responsibility of the social worker to effect the change of attitudes of both patient and family after the patient goes on visit from the hospital.

Whether or not the social worker achieves results in the better adjustment of the patients under her supervision depends on her skill in analysis and planning, in her knowledge of resources and in the personality of the patient. The social worker's skill is comprised of the ability to work with others; perseverance, patience; initiative and courage; self-confidence; ability to change a plan, or elasticity of mind; resourcefulness and orderliness; ability to keep the client always in mind; and to realize the needs of the patient and others. In analyzing and diagnosing a case

and making a plan for a patient under supervision she determines to what extent the patient and the key persons in the situation are modifiable, how their attitudes can be redirected, and to what extent the total situation is modifiable. She also determines what are the difficulties in the total situation that call for treatment, and the best methods of modifying them. She takes into account the positive as well as the destructive factors, and how best to secure the cooperation of others.

It is difficult to evaluate social service supervision, and to classify it as excellent, good, fair or poor. An attempt has been made here to make an evaluation on the basis of how nearly the patient has been assisted in reaching the goal of best adjusting to his total social situation; how well his attitudes have been re-directed, for better relationship with other members of the family and with others with whom he comes in contact. In other words, the social service supervision would seem to be excellent if the patient has been enabled to make a better social adjustment, with the highest degree of self-direction, independence and self-maintenance of which he is capable in his environment. If the patient has made a successful adjustment in his emotional life, in economic or educational responsibility, and above all in social relationships, under social service supervision, that supervision has been

successful. The writer believes that in all cases the patients made a better adjustment, and lived more happily and usefully in the community than they would have done without social service supervision. The cases reported were largely those who did not have families who could supervise them, and therefore they remained under the guiding wing of the social worker throughout their trial visit period. The workers felt a keen sense of responsibility with regard to those in their care, and much time and effort was spent with each individual patient placed by social service first in making the most suitable placement possible either in industry or some other environment particularly adapted to his needs, and then in supervising the patient. It was found that with intensive supervision many patients could adjust in the community whereas if left to make their way alone without encouragement and aid in solving their problems they more frequently returned to the hospital. The cases studied were those of patients who had remained outside the hospital at least four months. Patients who did not make a good adjustment or whose mental illness was especially acute were usually returned to the hospital in less than four months. The writer feels that the social service supervision in the 20 cases was adequate to the patients' needs, and was therefore good or excellent in all cases. The supervision included in-

terpretation to the patient, his family and associates of his difficulties, and the recommendations for treatment, social manipulation (finding jobs, recreational facilities, boarding homes) and modification of the environment.

The writer feels from the study of these 20 cases that the supervision of patients from a mental hospital is very worthwhile from the standpoint of the patient and his family, the hospital, and the community. The social worker acts as a link between the patient and his family; the family and community resources; the hospital and the patient, his family, and the community.

It would be interesting to study 20 cases who were released on visit from the hospital, without a pre-parole investigation and without supervision by the social service department, for purposes of comparison with the patients presented.

The employment of additional social workers to work with out-patients alone would be highly practical, as a larger proportion of the more than 500 patients who are on visit could be given more adequate supervision. These results of social service supervision, so valuable to the patient as found in the hospital and the community, could be obtained in a larger proportion of the cases if more social service visitors were available to give more adequate supervision.

The writer feels that the supervision by the social service department of the 20 patients on visit from the hospital shows that the social workers have fulfilled their function in their work with hospital patients, as summed up by Miss Crutcher:

> . . . the understanding handling of the social factors which seem to have contributed to the patient's illness.... With relief from certain pressures the patient can often live comfortably in the community. The social worker should be able to make the adjustments required to relieve such strain....The social case work which the well-trained worker is able to do now is a far cry from the errands and special investigations which formerly constituted her chief job....to help clear the patient's course so that he can work his way through the difficulties he has encountered in his psycho-physical environment. In some cases her relationship with the client is such that she serves as a release for his emotional tension, in others she may try to work out with the patient and his family certain plans based upon their conscious understanding of the situation, or she may merely make needed changes in the physical aspects of the patient's environment. In working out any plans... the social worker has in mind that through growth and development of the personalities involved more satisfactory and lasting adjustment can be expected.[3]

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3 Crutcher, op.cit., pp. 11-16.

BIBLIOGRAPHY

American Psychiatric Association, "Report of the Committee on Psychiatric Social Service", American Journal of Psychiatry, 13(90 old series): 434, September, 1933.

Crutcher, Hester B., A Guide for Developing Psychiatric Social Work in State Hospitals, Utica, New York: State Hospitals Press, 1933.

Dunham, H. Warren, "The Ecology of the Functional Psychoses in Chicago", American Sociological Review, 2:467-479, August, 1937.

French, Lois Meredith, Psychiatric Social Work, New York: The Commonwealth Fund, 1940.

Palmer, Gladys L. and Wood, Katherine D., Urban Workers on Relief, Washington: Works Progress Administration, 1936.

APPENDIX A

SCHEDULE

STUDY OF SOCIAL CHARACTERISTICS OF PATIENTS UNDER SUPERVISION, 1940-1941

Diagnosis _____ Hospital No. _____

SEX Male Female

CITIZENSHIP U.S. Other (specify)

NATIVITY U.S. Other (specify)

RACE White Negro Other

RELIGION Catholic Protestant Hebrew Other

MARITAL STATUS -Single Married Widowed Separated Divorced

AGE AT LAST RELEASE ON TRIAL VISIT

Under 9 years	40 to 49 years
10 to 19 years	50 to 59 years
20 to 29 years	60 to 69 years
30 to 39 years	70 to 79 years

LENGTH OF STAY IN THE HOSPITAL

Months- Under 1, 1-2, 2-3, 3-4, 4-5, 5-6, 6-7, 7-8, 8-9, 9-10, 10-11, 11-12

Years - 1-2, 2-3, 3-4, 4-5, 5-6, 6-7, 7-8, 8-9,9-10, 10-11, 12-13

More years (specify)

EDUCATION

Common school	High school
Grammar school	College
Special schools or courses	

Schedule cont.

Hospital No.

INTELLIGENCE

Borderline	High average
Dull Normal	Superior
Normal	

OCCUPATION

Before admission	After release on visit

ECONOMIC STATUS

	On admission	On release
Dependent		
Marginal		
Comfortable		

COURT RECORD (As reported by Mass. Board of Probation)

	Before admission	On release and after
No. of arrests		Offenses
Jail sentences served		

SOCIAL AGENCIES (as reported by Social Service Index)

No. of social agencies to which patient or family was known before his release

After release

MEDICAL DIAGNOSIS

Alcoholic Psychosis
Dementia Praecox
Manic Depressive
Paranoid Condition
Primary Behavior Disorders in Children, Conduct Disorders
Psychosis with Cerebral Arteriosclerosis
Psychosis with Mental Deficiency
Psychosis with Syphilitic Meningo-Encephalitis
Psychoneuroses
Undiagnosed Psychosis
Other

SOCIAL PROBLEMS

Educational adjustments
- Readjustment habits of mind
- Recreation
- Church
- Social relationships

Employment difficulties and financial troubles

Family friction

General problems

Legal difficulties

- Concerning property or support
- Resulting from conduct of patient
- Resulting from conduct of others

Marital difficulties

Mental disease

Personality problems
- Temperament
- Anti-social habits

Physical disease

Sexual difficulties

Unsuitable surroundings.

EVALUATION OF SOCIAL SERVICE SUPERVISION, AND OF PATIENT'S SOCIAL ADJUSTMENT

Excellent
Good
Fair
Poor

DEFINITIONS OF MAJOR TERMS USED IN THE SCHEDULE OF THE SUPERVISION STUDY.

Each definition is limited to the essential meaning of the term.

AGE. Was recorded in years for last birthday preceding the last release on visit.

COLOR OR RACE. Was reported in three groups: White, Negro, Other. If there was any known negro blood, the person was reported as negro.

DIAGNOSIS, MEDICAL. Was taken from the classification in the state hospital records.

EDUCATION. Was reported in total number of years completed in school.

MARITAL STATUS. Was reported in five groups: single, married, widowed, separated, divorced. Status was given as that at the time of release on visit.

OCCUPATION. Usual or principal occupation was defined as that occupation which a person considered to be his usual occupation or that at which he worked longest, or at which he worked last. Occupation meant any job for which a person received money or money equivalent, excluding unpaid housework.[1]

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[1] Adapted from: Gladys L. Palmer and Katherine D.Wood, Urban Workers on Relief (Washington: Works Progress Administration, 1936), p. 107.